Section

3

Using the MSDP Individualized Action Plan (IAP) Group Documentation Processes/Forms

This section provides a sample of each Action Plan Group form type, guidelines for the use of each form, and instructions for completion of the forms, including definitions for each data field.

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Individualized Action Plan – Version One

Treatment Planning is a collaborative process and per best practice guidelines, regulatory requirements, and accreditation standards must demonstrate active participation of the person served and/or his or her parent/guardian. The title "Individualized Action Plan" has been identified for use to capture all of the work or "actions", which may be utilized in the course of treatment for persons served by a variety of programs. The Individualized Action Plan (IAP) must be completed for every person served and be linked to the treatment recommendations/assessed needs from the Comprehensive Assessment or other approved document. This form has been designed to facilitate active participation and plan development with the person served and/or his or her parent/guardian and to document the goals and objectives identified collaboratively with the person served, as well as steps that will be taken by the person served, parent/guardian/community, and other providers to achieve the desired goal(s).

The form has been designed using components, which can be combined to capture the total number of goals and objectives identified. The components include a goal section with corresponding objectives, as well as a page that provides space for additional necessary information such as other agencies/community supports and resources supporting the IAP and a medication list (mandatory for outpatient substance use counseling only). In addition, a section is provided at the end of the plan to specify the Transition/Level of Care/Discharge Plan. While this may be new to some users, it is in fact a mandatory element of the treatment planning process.

Two versions of the IAP form are available: Version One and Version Two. Each of these forms has a corresponding "Additional Goals Sheet." Version One is required by DMH for CBFS providers as it requires the following sections for each goal:

- Person's Strengths, Preferences, and Skills and how they will be used to meet this goal.
- Supports and Resources needed to meet this goal.
- Potential Barriers to meeting this goal.

In Version Two, these fields are listed only once, and apply to all goals. Version Two is intended for levels of care that do not require these fields for each goal.

The user can use as many of the Additional Goals" pages as necessary to capture the total number of identified goals. The final page for both versions is the same. Once all goals and objectives are completed and the final page added, the total number of pages should be counted and page "x" of "y" should be indicated in the header of each page.

Note: For programs that are accredited by CARF or JCAHO be sure to include legal requirements as they relate to treatment including any restitution, e.g. court ordered treatment. For JCAHO include interaction with the criminal or juvenile justice system if applicable.

PACT: This form should be redone every 6 months.

Data Field	Identifying Information Instructions (*Fields for Person's Name, Record Number, and D.O.B. must be completed on each page)
*Person's Name	Record first name, middle initial and last name of the person served. Order of name is at agency discretion.
*Record Number	Record agency's established identification number for the person.
Date of Admission	Record date the person served was admitted.
Organization/Program Name	Record the organization and program for which you are delivering the service.
*D.O.B	Document date of birth of the person served.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Annual IAP-Date	Record date the annual IAP is due.
Revised IAP-Date	Record date the IAP was revised.
Linked to Assessed Need(s) # ____ from form dated _____	List the number of the treatment recommendation/assessed need from the date of an approved form. Check off or indicate the other form name that contains the treatment recommendation/assessed need identified. **Example:** **Treatment Recommendation # 1 from form dated 01/08/07: ☑ CA**

Start Date	The date the person served and provider(s) will begin to work on this goal.
Target Completion Date	Record the date by which the person served would like to accomplish the goal or the date by which the person served and provider(s) believe the goal can be completed.
Desired Outcomes for this Assessed Need in Person's Words	Document in the words of the person served his or her desired outcomes for the assessed need. This statement will be utilized in formulating the goal statement described below and can be used as a benchmark by the person served and provider for determining success in achieving the goal as treatment progresses. ***Child Outpatient Example:*** "I want to do better in school and play more with friends ***Adult Outpatient Example:*** "I don't want to experience an episode like those two again… and if I do, I want to know how to respond." ***CBFS Example:*** "I want to be normal. I want to be like everyone else and have my own apartment." ***BSAS Example:*** I want to stop snorting Oxycodone and get better control of my life.

Data Field	Goals/Desired Results/Target Date Instructions
Goal #	To identify goals, number sequentially. **Example: Goal # 1** (**Note:** individual programs may have differing requirements as to what components must be included in an Individualized Action Plan/Treatment Plan. Providers should follow contractual and regulatory standards as applicable, i.e. for the CBAT and ICBAT programs, the individual goal sheets can be used for medical, educational, family, etc. goals)
Goal (State Goal below in Collaboration with the Person Served/Reframe Desired Outcomes)	Reframe the desired outcome stated above by describing the goal from a clinical perspective in collaboration with the person served. Goals should be stated in attainable, behavioral/measurable terms. For some programs or courses of treatment, specific goals may be required (i.e. Tobacco Cessation, Medication Management, mandated treatment, etc.). ***Child Outpatient Example:*** Joel will be able to tolerate frustrating situations, reducing the number of incidents he has, such as walking away from his desk when frustrated by the work expectations. ***Adult Outpatient Example:*** Mary will learn the skills and strategies needed to decrease the frequency and intensity of her anxiety as evidenced by self-report and observation. (Initial Baseline: 2 moderate-to-severe panic attacks in 1 month and overall level of anxiety reported by Mary as a 7 out of 10, with 10 being the highest). ***CBFS Example:*** Jean will move into an apartment. ***BSAS Example:*** Robert will refrain from the use of opiate drugs and manage his stressors and social situations without the use of opiates.

Data Field	Person’s Strengths/Skills/Supports Instructions

Person's strengths, Preferences, and Skills and how they will be used to meet this goal	Document the strengths and skills the person served has that can be used to work towards and accomplish this goal. PACT: Identify potential challenges and the resources the person, team and community can use to manage those. Identify how the person has used their strengths in the past and how they have managed the issues presented up to this time. Use the information in the Comprehensive Assessment and the Interpretative Summary. **PACT Example:** Kevin is friendly, intelligent and motivated to make progress and maintain wellness. He has friends he speaks to on the phone and gets together on a regular basis. He is involved in the Church and goes to Boston weekly to participate in fellowship and services. Kevin earned A's for his two classes last semester. He is able to manage his class schedule and complete projects independently. Kevin seeks assistance from PACT if he experiences issues with sleeping, and he has frequent contact with family who notify pact regarding changes in mental status. Kevin has become more open to receiving supports and resources. Kevin moved into the Pathfinders housing program last fall and has followed all rules and procedures without difficulty. He gets along well with residents and staff. Kevin travels independently utilizing public transportation to navigate on a daily basis. Kevin began exercising last month to improve his health, as well as reducing his intake of potato chips and spam. Kevin reports that he trusts members of the PACT team and has a good relationship with his treatment team. ***Child Outpatient Example:*** Joel is a very curious and sweet child who shows engagement at times. ***Adult Outpatient Example:*** Mary has skills in caring for others and being compassionate that she can use towards herself. Mary is willing to participate in treatment and wants to "get better." ***CBFS Example:*** Jean is motivated and has a strong sense of perseverance, which she will be able to channel toward the tasks necessary to achieve living independently. Jean is interested and excited about the goal of independent living and will be able to use her interest to overcome obstacles and anxiety that may stand in the way of living independently. Jean has achieved her goal of becoming her own rep payee, which demonstrates that she has been able to pay her bills in a timely fashion and budget her money effectively. These skills will be useful for paying her rent, utilities and other bills she may acquire. Jean is an experiential learner and learns skills quickly after someone has demonstrated the skill and then gives her the opportunity to attempt it herself. This will be an asset to Jean when she begins to search for apartments, develop budgets, practice coping skills with staff and completes applications and searches for jobs. Jean goes to all of her appointments independently and is effective at communicating her needs to her family and providers. Jean's timeliness, commitment to her goals and effective communication should assist her in working with staff, communicating with potential landlords and employers. In addition Jean has the support of her brother and mother. Jean's family is actively involved in her life and is willing to participate in helping her reach her goal of moving into her own apartment. Jeans brother has indicated that he would like to help her find and apartment and her mother would like to attend yoga classes with her regularly. The involvement of her family will not only help her with the short term goal of achieving an apartment but it also provides Jean with a sense of belonging. Jean has stated "Although sometimes the relationships with my family can be a little difficult, when I am with them I know that I am with people who know me well and care about me" ***BSAS Example:*** Robert is intelligent and insightful. He appears motivated to change /improve his life and his situation.
Supports and Resources needed to meet this goal	List supports and resources that will be needed to accomplish the goal. Include natural and community supports as well as cultural and linguistic needs of the person and any reasonable accommodations/modifications to policies or practices that will be made. Be sure to consider supports beyond the behavioral health system to facilitate recovery and resiliency. **PACT Example:** Kevin lives in at the pathfinders housing program where he can seek assistance if needed from available staff members. He has several visits with the PACT team weekly to problem solve and brainstorm solutions to any

	difficulties he may be experiencing. Kevin has a close relationship with the PACT psychiatrist whom he meets with every other week to discuss his sleep hygiene, and discuss any concerning symptoms he may be experiencing. Kevin has the support of disability services offered at UMass Lowell to assist him in troubleshooting any questions he has regarding assignments or his school work. Kevin finds his family helpful in providing him emotional support and assisting him with preparing newer foods lower in fat and caloric intake. Kevin finds his church a great support to access on a weekly basis to "keep him focused and moving forward in life." ***Child Outpatient Example:*** Joel will need the support of his family and school to achieve this goal. ***Adult Outpatient Example:*** Her children, her primary care physician, a couple friends, her church/faith, therapist ***CBFS Example:*** Jean's brother is willing to assist Jean in signing up for section 8 housing. She will need the support of staff in preparing for independent living. She will need a copy of the program's medication independence plan in order to learn the steps toward medication independence. Jean will also need the assistance of the Employment Specialist to search for a job. Jean's mother is willing to assist her by taking her to yoga class, and the program will connect her with IMR group to help her toward her goal of managing her anxiety. ***BSAS Example:*** Robert needs to explore healthier social activities. He needs to develop alternative activities with a social group that is not surrounded by recreational drug use.
Potential Barriers to meeting this goal	Record any potential barriers to meeting the goal, which the person served identifies or that were identified while developing the IAP. **PACT Example:** Kevin has found it difficult to remain in mental health treatment in the past. He reports "sometimes I just think I can do it on my own and that people will be good to me along the way and I can make it without medication." In the past he has eloped from treatment and currently reports that he is "unsure" of what signs and symptoms have led to previous inpatient hospitalizations. Kevin experiences difficulty sleeping which interferes in several areas of his life including his ability to perform in school and to attend appointments as scheduled with providers. Kevin is prescribed PRN medications which he is reluctant to utilize unless he receives instruction that day from PACT staff to do so. Kevin reports that he "stresses out about sleeping" and this will only "make it worse." Kevin struggles with symptoms of stress and anxiety and would benefit from additional coping skills to best manage these symptoms. ***Child Outpatient Example:*** Joel needs neuropsychological testing to help support school services and possible school placement issues in order for his frustration a t school to diminish. ***Adult Outpatient Example:*** Mary noted that attending sessions could be difficult when school was not in session or one of her children was ill. ***CBFS Example:*** Jean reports that she doesn't have a lot of experience in obtaining an apartment. Jean is unaware of the steps involved in finding, obtaining and maintaining an apartment and Section 8 housing. She will need assistance in finding an apartment that meets her needs, satisfies her wants and that she can afford. Jean is concerned about managing her money when she is on her own and in an apartment and has additional income from employment. Initially Jean has asked for assistance in determining how much she can spend on an apartment and still be able to manage bills such as electric and her cell phone. Jean reports having limited experience with living independently and does not know the average costs of rent, electric and heating bills. Jean will benefit from the support of staff in this area. Jean is also not aware of any entitlements or subsidies that she might be eligible for. Jean views being medication independent as a very important step to her being successful in her own apartment. Jean has indicated that if she has a job and is not living at Alsada that it may be complicated for her to meet up with staff to receive her medications twice a day and would prefer to be as independent in this area as she can be before moving into an apartment. Jean does not currently administer her own medication and is uncertain of the protocols she must follow in order to self-administer. Jean would like assistance in identifying her medications and implementing ways to help her remember to take her medications.

	Jean identifies that when she is overwhelmed she experiences anxiety which can lead to substance use, suicidal thoughts and auditory hallucinations. Jean is worried that taking on such a drastic life change could lead to anxiety. Jean is interested in learning new skills and implementing a daily regime to help her to manage stress. Jean will benefit from the support of staff in this area through additional skills training. Jean would like to get a part time job. Jean has not had a job in the past and is unsure of what type of job she would like, how to find a job and that she will be to shy to complete interviews. Jean will benefit from staff working with her as well as the Supported Employment Specialist to increase her knowledge and confidence in this area. ***BSAS Example:*** Robert has been involved long term in a drug use culture.

Data Field	Objectives Instructions
GOAL # ___	Identify the number of the goal to which the objective applies.
OBJECTIVE # ___	Number each objective sequentially and link to the appropriate goal **Examples:** • **Goal #1/Objective #1** • **Goal #1/Objective #2**
(OBJECTIVE)	Describe in measurable terms an objective that will assist the person served in reaching the identified goal. NOTE: If additional objectives are needed for a specific goal, insert an additional page two. **PACT Example:** Kevin will engage in actions which promote his recovery ***Child Outpatient Example:*** Joel will learn how to regulate his emotions in order for him to avoid getting to the point of intolerable frustration. ***Adult Outpatient Example:*** 1. Develop skills to identify and manage triggers to her anxiety in efforts to reduce her anxiety (IBL: 7 out of 10 with 10 being highest). 2. Find and develop at least 3 grounding and relaxation skills to use when experiencing anxiety. ***CBFS Example:*** Jean will choose an apartment. Jean will package her meds for one week at a time. Jean will use two coping skills per month for a period of six months to reduce her anxiety as she prepares for major life changes. Jean will get a part time job. ***BSAS Example:*** Robert will develop a recovery plan which will include 3 relapse prevention and skill building strategies.
Person Served Will	Indicate the specific actions the person served will take to support achievement of the stated objective. **PACT Example:** Kevin will identify actions and behaviors which assist him in managing his symptoms and utilize these coping skills to promote his recovery ***Child Outpatient Example:*** Joel will cooperate with clinician, parents and school to participate in learning new methods for regulating his emotions., so any outbursts or avoidance of feelings will be reduced by 50%. ***Adult Outpatient Example:*** 1. Consider triggers in her previous panic attacks in session; Track her levels of anxiety for a couple weeks; Practice developing the ability to recognize triggers in the moment, 2. Practice several coping, grounding, or relaxation skills and identify her favorites; Practice self-care activities on a daily basis; Identify and practice a better nighttime sleep routine ***CBFS Example:*** Jean will complete and submit her application for Section 8 housing and apply for any other entitlements that she is eligible for. Jean will review the program's medication independence plan and review the steps outlined in the plan. ***BSAS Example:*** Robert will list healthy activities and new people he can count on to participate in healthy non drug using activities.
Start Date:	The date the work on this objective will start.

Parent/Guardian/ Community/Other Will	Indicate the actions/support the parent/guardian/community/ others will provide to assist the person served in accomplishing the objective. If family or other involvement is not clinically indicated, check box. **PACT Example:** Kevin's church will be utilized on a weekly basis, and he will remain in close contact with his family to support him in his wellbeing. ***Child Outpatient Example:*** Practice skills at home on a daily basis by creating situations that would cause frustration for Joel, such as through playing a board game with him that he will lose. Mother will record how frequently Joel becomes frustrated and she will comfort Joel and intervene with having him identify his feelings. Mother and Joel can practice deep breathing that mother learned from clinician. ***Adult Outpatient Example:*** N/A ***CBFS Example:*** Jean's brother will help her apply for Section 8 housing. ***BSAS Example:*** Family involvement is not indicated at this time.
Target Completion Date	Record the date by which the person served would like to accomplish the objective or the date by which the person served and provider(s) believe the objective can be completed.

Data Field	Interventions and Service Description Instructions
Intervention(s)/ Method(s)	Describe the actual therapeutic or rehabilitative interventions/methods the clinician/trained other staff will provide to support/facilitate the person served in achieving the stated objective. *This is not the type or modality of the service (i.e. do not write "CBT" or "Individual Therapy" alone. The statement should be descriptive of the actual methods).* **PACT Example: 1.** Kevin will discuss signs he has experienced which have led to hospitalization in the past, and create a plan with staff to manage these signs and symptoms moving forward. 2. Kevin will develop a sleep hygiene routine to utilize nightly to assist with sleeping well. 3. Kevin will continue to practice heart math biofeedback with PACT staff for relaxation and stress management. 4. Kevin will utilize CommonGround resources on a regular basis, update his personal medicine and power statement and complete a health report prior to any appointments with his psychiatrist. ***Child Outpatient Example:*** Through directed play, Joel will be placed in situations in which he would most likely lose at a game or a battle (with figurines) or any other type of situation which would make him frustrated. Joel will practice identifying feelings by using an "Expressions Poster". Joel will do body mapping and be able to identify where in his body he feels his feelings. ***Adult Outpatient Example:*** 1. Provide psychoeducation and discuss with Mary common contributing factors to and forms of anxiety; Facilitate Mary in tracking her levels of anxiety and recording her experiences of panic attacks (including assessing for precipitating events, hunger, emotions beforehand, etc); Aid Mary in identifying triggers to her anxiety (including exploring negative thoughts if appropriate); Converse with Mary's primary care physician as appropriate. 2. Evaluate with Mary her current coping strategies; Provide psychoeducation about coping, grounding, and/or relaxation skills and aid Mary in discovering which work best for her; Provide psychoeducation about self-care and sleep hygiene ***CBFS Example:*** 1.Teach Jean apartment search skills, for the purpose of finding available apartments, by reviewing with her the different housing resources in the area such as newspapers, internet searches and other tools. Teach Jean how to narrow down her apartment choices by helping her to create a written list of questions to ask potential landlords when looking at an apartment. 2. Teach Jean how to determine which apartment best suites her needs for the purpose of choosing an apartment by filling out a pros and cons list of the apartments she visited, examining the pros and cons list and identifying the most suitable apartment. 1. Teach Jean coping skills for the purpose of helping to prepare herself for stressful situations by helping her create a way to identify her stress triggers and choose skills that may help her to deal with situations effectively. 2'Teach Jean IMR's Stress Vulnerability Model for the purpose of managing stress by reviewing the listed skills and discussing how and when these skills may be used effectively.

	1. Teach Jean job search skills for the purpose of helping her find a job by showing her how to fill out applications, both in paper form and online, and teaching her how to create a resume. 2. Teach Jean job identification skills by helping her to assess her interests and skills by completing various work sheets out of the "The Pathfinder: How to Choose or Change Your Career for a Lifetime of Satisfaction and Success" book or other materials. Teach Jean how to identify jobs that meet her interests and skills. ***BSAS Example:*** Robert will attend recovery skills building group for young people Group therapy will explore / practice recovery skills . The group will practice techniques such as role playing and refusal skills building. The use of replacement / alternative behaviors designed to break unhealthy patterns that have been developed. Robert will change people, places and things that involve substance using activities.
Service Description/ Modality	Indicate the types of services the person will receive. Because this is a comprehensive plan this may not necessarily be a behavioral health service. PACT: Use this section to identify the interventions and Evidence –Based practices and community resources that will be used. **Examples:** • **Family Therapy** • **Individual therapy** • **Couples therapy** • **Group therapy** • **Psychopharmacology** • **Case management**
Frequency	Indicate how often this service/activity will occur. For some services, the total number of hours ordered may need to be included. Please refer to agency-specific guidelines. **Examples:** • **Daily** • **.5 hours Weekly** • **Bimonthly** • **4 hours per week**
Responsible (Type of Provider)	Indicate the credential or title of the program staff, not the specific individuals, that are responsible for providing the services listed. If the types of providers listed are not eligible to provide the service according to regulation or payer rules, the service may not be billable. If services are provided in a team format, the primary provider type should be listed. **Examples:** • **Psychiatrist** • **Nurse** • **Therapist** • **Community Support Staff** • **Case Manager**

Data Field	Medication Information

Medications as Reported by Person Served on Date of IAP	**NOTE: <u>This section is mandatory for outpatient substance use counseling programs only.</u>** If not applicable, check the box provided. PACT: N/A Complete the information in the table as reported by the person served on the date that the IAP was developed. Complete all fields for each medication including name of medication, dose, plans for change (including rate of detoxification), and the person prescribing each medication.

Data Field	Identifying Information/Agencies Instructions
Other Agencies/ Community Supports and Resources Supporting IAP	List the agency name, contact person/title, and services currently being provided by external agencies/community supports and resources that are collaborating on or supporting the person's IAP. Indicate whether or not the appropriate release has been signed to allow for communication with each. Check if "None Reported" or "No Change". PACT: This section may be used if applicable: e.g. DSS or as the person is being transitioned. **Examples:** • **Other Mental Health agencies** • **State Departments (i.e. DSS, DMR, DMH)** • **Doctor/Nurse** • **Court/Probation Officer**

Data Field	Transition/Level of Care Change/Discharge Plan
Anticipated Date	Record the date of anticipated transition/discharge based on person's belief of when the criteria for such transition would be met and/or provider assessment. If No Change, check appropriate box.

Criteria: How will the provider/individual/ parent/ guardian know that level of care change is warranted?	Transition planning should begin as early as possible in the treatment process and documentation of the planning is required. To facilitate the process, check boxes have been provided. Check all that apply and document evidence, which supports or describes any criteria checked. **PACT Example:** Being able to identify and plan for increased signs and symptoms and how to navigate through these symptoms successfully. Engaging in a regular sleep pattern to help promote achieving academic success/ availability to attend appointments with providers. Finding and utilizing new coping skills to best manage symptoms of stress and anxiety. ***Child Outpatient Example:*** Reduction of symptoms as evidenced by a decrease in anxiety, increase in eye contact, increase in tolerance for frustration most of the time, ability to identify feelings. Attainment of higher level of functioning as evidenced by: ability to engage in reciprocal conversation without cues; ability to be stopped and redirected when going off on a verbal tangent; ability to interact appropriately with peers ***Adult Outpatient Example:*** Treatment is not longer medically necessary as evidenced by: Mary feeling capable to notice and diminish panic attacks to the level that she no longer is worried about them. ***CBFS Example:*** Jean and her treatment providers will know that she is ready for a more independent level of care when she has identified an apartment to live in and demonstrates the use of positive coping skills when she experiences anxiety. Jean has identified that she wants to have a job prior to moving into an apartment in order to gain the confidence to live independently. Therefore Jean will also obtain and maintain employment before the level of care changes. ***BSAS Example:*** Evidenced by the reduction of symptoms as evidenced by discontinuation of use.

Data Field	Signatures/Confirmation Instructions
Plan Completed by	Record the name of the person completing the IAP, his or her title, and the program(s) for which the plan is being developed.
Was the person served provided with copy of the IAP?	Check appropriate box indicating whether or not the person served received a copy of the IAP. If "No", document reason.
Person's Signature (Optional, if clinically appropriate)	The person served **should** be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a Progress Note and list the date here.
Date	Date of person's signature.
Parent/Guardian Signature	The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives.
Date	Date of Parent/Guardian Signature.

Data Field	Staff Signatures Instructions
Clinician/Provider – Print	**Legible** clinician/provider name and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.

Name/Credential	
Date	Date of this signature.
Supervisor – Print Name/Credential (if needed)	**Legible** supervisor name and credentials, according to agency policy.
Date	Date of this signature.
Clinician/Provider Signature	**Legible** signature according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date	Date of this signature.
Supervisor's Signature(if needed)	**Legible** signature and credentials of supervisor. **Example: Jerry Smith, LMHC**
Date	Date of this signature.
Physician/MD/DO Signature (if required)	**Legible** physician's signature if required by agency policy. Please note certain payers do require physician's signature.
Date	Date of this signature.
Next Appointment	Enter the date and time, indicating am or pm for the next scheduled appointment, if known.

Individualized Action Plan – Version Two

Treatment Planning is a collaborative process and per best practice guidelines, regulatory requirements, and accreditation standards must demonstrate active participation of the person served and/or his or her parent/guardian. The title "Individualized Action Plan" has been identified for use to capture all of the work or "actions", which may be utilized in the course of treatment for persons served by a variety of programs. The Individualized Action Plan (IAP) must be completed for every person served and be linked to the treatment recommendations/assessed needs from the Comprehensive Assessment or other approved document. This form has been designed to facilitate active participation and plan development with the person served and/or his or her parent/guardian and to document the goals and objectives identified collaboratively with the person served, as well as steps that will be taken by the person served, parent/guardian/community, and other providers to achieve the desired goal(s).

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Two versions of the IAP form are available: Version One and Version Two. Each of these forms has a corresponding "Additional Goals Sheet." Version One is required by DMH for CBFS providers as it requires the following sections for each goal:

- Person's Strengths, Preferences, and Skills and how they will be used to meet this goal.
- Supports and Resources needed to meet this goal.
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The user can use as many of the Additional Goals" pages as necessary to capture the total number of identified goals. The final page for both versions is the same. Once all goals and objectives are completed and the final page added, the total number of pages should be counted and page "x" of "y" should be indicated in the header of each page.

Note: For programs that are accredited by CARF or JCAHO be sure to include legal requirements as they relate to treatment including any restitution, e.g. court ordered treatment. For JCAHO include interaction with the criminal or juvenile justice system if applicable.

PACT: Identify and group goals by the 7 PACT areas to the extent possible. This form should be redone annually.

Data Field	Identifying Information Instructions (*Fields for Person's Name, Record Number, and D.O.B. must be completed on each page)
*Person's Name	Record first name, middle initial, and last name of the person served. Order of name is at agency discretion.
*Record Number	Record agency's established identification number for the person.
Date of Admission	Record date the person served was admitted.
Organization/Program Name	Record the organization and program for which you are delivering the service.
*D.O.B	Document date of birth of the person served.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Annual IAP-Date	Record date the annual IAP is due.
Revised IAP-Date	Record date the IAP was revised.

Data Field	Person's Strengths/Skills/Supports Instructions
Person's strengths, Preferences, and Skills and how they will be used to meet this goal	Document the strengths and skills the person served has that can be used to work towards and accomplish this goal. ***Child Outpatient Example:*** Joel is a very curious and sweet child who shows engagement at times. ***Adult Outpatient Example:*** Mary has skills in caring for others and being compassionate that she can use towards herself. Mary is willing to participate in treatment and wants to "get better." ***BSAS Example:*** Robert is intelligent and insightful. He appears motivated to change /improve his life and his situation.
Supports and Resources needed to meet this goal	List supports and resources that will be needed to accomplish the goal. Include natural and community supports as well as cultural and linguistic needs of the person and any reasonable accommodations/modifications to policies or practices that will be made. Be sure to consider supports beyond the behavioral health system to facilitate recovery and resiliency. ***Child Outpatient Example:*** Joel will need the support of his family and school to achieve this goal. ***Adult Outpatient Example:*** Her children, her primary care physician, a couple friends, therapist ***BSAS Example:*** Robert needs to explore healthier social activities. He needs to develop alternative activities with a social group that is not surrounded by recreational drug use.
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Person Served Will	Indicate the specific actions the person served will take to support achievement of the stated objective. ***Child Outpatient Example:*** Joel will cooperate with clinician, parents and school to participate in learning new methods for regulating his emotions., so any outbursts or avoidance of feelings will be reduced by 50%. ***Adult Outpatient Example:*** 1. Consider triggers in her previous panic attacks in session; Track her levels of anxiety for a couple weeks; Practice developing the ability to recognize triggers in the moment, 2. Practice several coping, grounding, or relaxation skills and identify her favorites; Practice self-care activities on a daily basis; Identify and practice a better nighttime sleep routine ***BSAS Example:*** Robert will list healthy activities and new people he can count on to participate in healthy non drug using activities.
Parent/Guardian/ Community/Other Will	Indicate the actions/support the parent/guardian/community/ others will provide to assist the person served in accomplishing the objective. If family or other involvement is not clinically indicated, check box. ***Child Outpatient Example:*** Reinforce skills at home. Advocate for Joel to get testing and further supportive services at school to help support his goals. ***Adult Outpatient Example:*** N/A ***BSAS Example:*** Family involvement is not indicated at this time.

Data Field	Goals/Desired Results/Target Date Instructions
Goal #	To identify goals, number sequentially. **Example: Goal # 1** (**Note:** individual programs may have differing requirements as to what components must be included in an Individualized Action Plan/Treatment Plan. Providers should follow contractual and regulatory standards as applicable, i.e. for the CBAT and ICBAT programs, the individual goal sheets can be used for medical, educational, family, etc. goals)
Linked to Assessed Need(s) # ____ from form dated _____	List the number of the treatment recommendation/assessed need from the date of an approved form. Check off or indicate the other form name that contains the treatment recommendation/assessed need identified. **Example:** **Treatment Recommendation # 1 from form dated 01/08/07: ☑ CA**
Start Date	The date the person served and provider(s) will begin to work on this goal.
Target Completion Date	Record the date by which the person served would like to accomplish the goal or the date by which the person served and provider(s) believe the goal can be completed.
Desired Outcomes for this Assessed Need in Person's Words	Document in the words of the person served his or her desired outcomes for the assessed need. This statement will be utilized in formulating the goal statement described below and can be used as a benchmark by the person served and provider for determining success in achieving the goal as treatment progresses. **Examples:** ***Child Outpatient Example:*** "I do not want to feel out of control". ***Adult Outpatient Example:*** "I don't want to experience an episode like those two again… and if I do, I want to know how to respond." ***BSAS Example:*** I want to stop snorting Oxycodone and get better control of my life.
Goal (State Goal below in Collaboration with the Person Served/Reframe Desired Outcomes)	Reframe the desired outcome stated above by describing the goal from a clinical perspective in collaboration with the person served. Goals should be stated in attainable, behavioral/measurable terms. For some programs or courses of treatment, specific goals may be required (i.e. Tobacco Cessation, Medication Management, mandated treatment, etc.). ***Child Outpatient Example:*** Decrease emotional outbursts or avoidance due to frustration. ***Adult Outpatient Example:*** Mary will learn the skills and strategies needed to decrease the frequency and intensity of her anxiety as evidenced by self-report and observation. (Initial Baseline: 2 moderate-to-severe panic attacks in 1 month and overall level of anxiety reported by Mary as a 7 out of 10, with 10 being the highest). ***BSAS Example:*** Robert will refrain from the use of opiate drugs and manage his stressors and social situations without the use of opiates.

Data Field	Objectives Instructions
OBJECTIVE # ___	Number each objective sequentially and link to the appropriate goal **Examples:** • **Goal #1/Objective #1** • **Goal #1/Objective #2**
(OBJECTIVE)	Describe in measurable terms an objective that will assist the person served in reaching the identified goal. NOTE: If additional objectives are needed for a specific goal, insert an additional page two. ***Child Outpatient Example:*** Joel will learn how to regulate his emotions in order for him to avoid getting to the point of intolerable frustration.

	Adult Outpatient Example: 1. Develop skills to identify and manage triggers to her anxiety in efforts to reduce her anxiety (IBL: 7 out of 10 with 10 being highest)_ 2. Find and develop at least 3 grounding and relaxation skills to use when experiencing anxiety ***BSAS Example:*** Robert will develop a recovery plan which will include 3 relapse prevention and skill building strategies.

Data Field	Interventions and Service Description Instructions
Intervention(s)/ Method(s)	Describe the actual therapeutic or rehabilitative interventions/methods the clinician/trained other staff will provide to support/facilitate the person served in achieving the stated objective. *This is not the type or modality of the service (i.e. do not write "CBT" or "Individual Therapy" alone. The statement should be descriptive of the actual methods).* ***Child Outpatient Example:*** 1. Through directed play, Joel will be placed in situations in which he would most likely lose at a game or a battle (with figurines) or any other type of situation which would make him frustrated. 2. Joel will practice identifying feelings by using an "Expressions Poster". 3. Joel will do body mapping and be able to identify where in his body he feels his feelings ***Adult Outpatient Example:*** 1. Provide psychoeducation and discuss with Mary common contributing factors to and forms of anxiety; Facilitate Mary in tracking her levels of anxiety and recording her experiences of panic attacks (including assessing for precipitating events, hunger, emotions beforehand, etc); Aid Mary in identifying triggers to her anxiety (including exploring negative thoughts if appropriate); Converse with Mary's primary care physician as appropriate 2. Evaluate with Mary her current coping strategies; Provide psychoeducation about coping, grounding, and/or relaxation skills and aid Mary in discovering which work best for her; Provide psychoeducation about self-care and sleep hygiene ***BSAS Example:*** Robert will attend recovery skills building group for young people Group therapy will explore / practice recovery skills. The group will practice techniques such as role playing and refusal skills building. The use of replacement / alternative behaviors designed to break unhealthy patterns that have been developed. Robert will change people, places and things that involve substance using activities.
Start Date	The date the work on this objective will start.
Target Completion Date	Record the date by which the person served would like to accomplish the objective or the date by which the person served and provider(s) believe the objective can be completed.
Service Modality	For each Service Modality used to accomplish the intervention, Indicate the Service Modality (e.g. Individual Therapy, Couple/Family, other), as well as the frequency and type of provider.
Frequency	Indicate how often this service/activity will occur. For some services, the total number of hours ordered may need to be included. Please refer to agency-specific guidelines. **Examples:** • **Daily** • **.5 hours Weekly** • **Bimonthly** • **4 hours per week**
Type of Provider	Indicate the credential or title of the program staff, not the specific individuals, that are responsible for providing the services listed. If the types of providers listed are not eligible to provide the service according to regulation or payer rules, the service may not be billable. If services are provided in a team format, the primary provider type should be listed. **Examples:** • **Psychiatrist** • **Nurse** • **Therapist** • **Community Support Staff** • **Case Manager**

Data Field	Medication Information
Medications as Reported by Person Served on Date of IAP	**NOTE: <u>This section is mandatory for outpatient substance use counseling programs only.</u>** If not applicable, check the box provided. Complete the information in the table as reported by the person served on the date that the IAP was developed. Complete all fields for each medication including name of medication, dose, plans for change (including rate of detoxification), and the person prescribing each medication.

Data Field	Identifying Information/Agencies Instructions
Other Agencies/ Community Supports and Resources Supporting IAP	List the agency name, contact person/title, and services currently being provided by external agencies/community supports and resources that are collaborating on or supporting the person's IAP. Indicate whether or not the appropriate release has been signed to allow for communication with each. Check if "None Reported" or "No Change". **Examples:** • **Other Mental Health agencies** • **State Departments (i.e. DSS, DMR, DMH)** • **Doctor/Nurse** • **Court/Probation Officer**

Data Field	Transition/Level of Care Change/Discharge Plan
Anticipated Date	Record the date of anticipated transition/discharge based on person's belief of when the criteria for such transition would be met and/or provider assessment. If No Change, check appropriate box.
Criteria: How will the provider/individual/ parent/ guardian know that level of care change is warranted?	Transition planning should begin as early as possible in the treatment process and documentation of the planning is required. To facilitate the process, check boxes have been provided. Check all that apply and document evidence, which supports or describes any criteria checked. Examples: ***Child Outpatient Example:*** Reduction of symptoms as evidenced by a decrease in anxiety, increase in eye contact, increase in tolerance for frustration most of the time, ability to identify feelings. Attainment of higher level of functioning as evidenced by: ability to engage in reciprocal conversation without cues the majority of the time; ability to be stopped and redirected when going off on a verbal tangent; ability to interact appropriately with peers ***Adult Outpatient Example:*** Treatment is not longer medically necessary as evidenced by: Mary feeling capable to notice and diminish panic attacks to the level that she no longer is worried about them. ***BSAS Example:*** Evidenced by the reduction of symptoms as evidenced by discontinuation of use.

Data Field	Signatures/Confirmation Instructions
Plan Completed by	Record the name of the person completing the IAP, his or her title, and the program(s) for which the plan is being developed.
Was the person served provided with copy of the IAP?	Check appropriate box indicating whether or not the person served received a copy of the IAP. If "No", document reason.
Person's Signature (Optional, if clinically appropriate)**:**	The person served **should** be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a Progress Note and list the date here.
Date	Date of person's signature.
Parent/Guardian Signature	The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives.
Date	Date of Parent/Guardian Signature.

Data Field	Staff Signatures Instructions
Clinician/Provider – Print Name/Credential	**Legible** clinician/provider name and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date	Date of this signature.
Supervisor – Print Name/Credential (if needed)	If applicable, **legibly** record signature and credentials of supervisor.
Date	Date of this signature.
Clinician/Provider Signature	**Legible** signature, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date	Date of this signature.
Supervisor's Signature (if needed)	**Legible** signature and credentials of supervisor. **Example: Jerry Smith, LMHC**
Date	Date of this signature.
Physician/MD/DO Signature (if required)	**Legible** physician's signature if required by agency policy. Please note certain payers do require physician's signature.
Date	Date of this signature.
Next Appointment	Enter the date and time, indicating am or pm for the next scheduled appointment, if known.

Individualized Action Plan Review/Revision

The Individualized Action Plan Review/Revision form has been created to document information from ongoing review(s), revision(s) of treatment goals and objectives and/or periodic rewrites. This form has been designed to minimize duplication of effort in creating subsequent action plans and maximize the documentation of information, which demonstrates evidence and/or rationale for revision.

Use the IAP Review/Revision form to update or modify the IAP in any of the following ways: 1) Revisions – to add a new goal; change goals, objectives or interventions; or change the frequency or duration of services; 2). Reviews – to record the progress of the person served and 3) Rewrites - annually, after three interim revisions, or per agency protocol, a "rewrite" of the actual IAP is warranted. This will facilitate the identification and tracking of treatment goals/objectives and progress made.

Use both pages of the Individualized Action Plan Review/Revision form for either a Review or Revision; Additional goal and/or objective sheets should be added as necessary. If you are adding a new goal or objective, attach the goal and/or objective page(s) from the IAP form to the IAP Review/Revision form.
When a Rewrite is being completed, page 1 of the IAP Review/Revision should be used and the new IAP should be attached.

If a goal/objective is new and not currently supported by the most recent Comprehensive Assessment, it is important to also complete a Comprehensive Assessment Update form.

Please note that this form does not have a billing strip. If you are reviewing progress in a way that is billable, e.g. meeting face-to-face with the person served to discuss progress and update the IAP, you also must complete a Progress note that describes the service and refers the reader to the IAP update. Use the billing strip on the bottom of progress note to bill for the service.
This form should be placed in date order (or according to internal policy and procedure) with the original IAP and any other updates. Together these documents will constitute the current IAP from which services are provided and billed. It is important to remember that as with the IAP, any IAP revisions should be completed in collaboration with the person served. This form requires evidence of collaboration in a number of ways. In all cases, if a person refuses to collaborate, does not agree to goals, or will not review goals, a separate progress note should be written to describe the person's participation and the plan for moving forward.

PACT: Complete 6 months after the full IAP is developed. Use to document mini-team meetings.

Data Field	Identifying Information Instructions (*Fields for Client Name, Number, and D.O.B. must be completed on each page)
*Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
*Record Number	Record your agency's established identification number for the person.
Date of Admission	Record date of admission.
Organization/Program Name	Record the organization/program for whom you are delivering the service.
*D.O.B	Document date of birth of the person served.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.

Data Field	Status and Evidence/Rationale Instructions
Goal Status	Check off and number each goal from the IAP being reviewed/revised. Use the space provided to either write out the goal statement or identify with a key word. Indicate whether the goal is Active, New, Discontinued, Completed, or Revised by checking the appropriate box. • If "Active" check to indicate progress towards meeting the goal. • If "Discontinued" log actual date of goal discontinuation. • If "Completed" log actual date of goal completion.
Objective Status	Under each identified goal, check off and number the current objectives being reviewed/revised. Indicate whether the objective is Active, New, Discontinued, Completed, or Revised by checking the appropriate box.
Evidence of Progress, Barriers, and/or	Use this space to document information regarding the person served and his or her treatment, which provides evidence and/or rationale for revisions and/or addition/discontinuation of goals or rewrite of the IAP. This section should summarize the progress towards meeting each goal

Data Field	Status and Evidence/Rationale Instructions
Rationale for Addition of New Goal/Discontinuation of Goal, Revision or Rewrite	and its respective objectives in the current plan, as well as describe any barriers, which have contributed to the person's difficulty or not meeting goals. Link progress/lack thereof to outcomes data when possible. ***Child Outpatient Example:*** Joel is now able to identify 10 expressions for the Expressions Poster. Joel has had fewer instances of becoming frustrated in school and has been able to go to a quiet area of the classroom for a few minutes to regroup and then he is able to join the rest of the students one out of 4 times. ***Adult Outpatient Example:*** Mary reports her anxiety has decreased from a 7 (Initial Baseline) to a 5. She has had two more panic attacks, and has used the grounding and relaxation skills during the latter. Her relationship with her husband has become "more difficult" than during intake. Mary is now interested in couples counseling. ***CBFS Example:*** Objective 1 - Jean Will Choose and Apartment: Partially Met Jean has worked with her case coordinator on determining her preferences for an apartment. She has decided that she would like to look for a one bedroom apartment that is close to a park, a grocery store and a bus stop. She has not yet determined the price range for the apartment search because she is currently seeking a part time job to supplement her benefit income. She would like to wait until she knows what her monthly income will be before starting the search. Jean has also applied for Section 8 housing. Objective 2 - Jean will package her meds for one week at a time: Partially Met Jean has begun to package her morning medications. She knows all of her medications and doses. She has also set an alarm on her cell phone to remind her about medications times. At this time, she still needs staff assistance with her evening medications but was able to identify that her barrier to being independent with nighttime medications is that she would prefer to stay up late and watch her favorite TV show. Jean is willing to work with her case coordinator to problem solve a way that she will be able to take her night medications without sacrificing the enjoyment of her favorite show. Objective 3 - Jean will use two coping skills per month for a period of six months to reduce her anxiety as she prepares for major life changes: Met Jean has attended IMR group for the past three months and attended modules about stress vulnerability and coping skills. Jean frequently uses skills such as running and talking to her brother to help in times of stress. Jean noted that she tried meditation but did not find it helpful. She was also able to try painting and singing to deal with stress, which she states "has really helped me out a few times." Jean attended yoga class with her mother for several weeks but identified feeling an increase in stress during those sessions due to her mother's level of stress. Jean felt that the yoga may be helpful if she could do it on her own and endorsed the idea of working with her case coordinator to identify free methods of getting involved in yoga. Though Jean has remained consistent in using 2 coping skills per month for six months, she would like this objective to remain active at this time because she is concerned that she will not use coping skills consistently yet without having it on her goal list. Objective 4 - Jean will get a part time job: Not Met Though Jean has not yet secured a part time position, she has submitted several applications to local businesses and has interviewed with 3 different companies. She quickly learned how to create her resume and fill out applications. She has been very professional in her interview role plays with the Supported Employment Specialist. She has demonstrated tremendous motivation toward the job search process and remains hopeful, stating, "It's just a matter of time before someone hires me." ***BSAS Example:*** At 6 months client has been struggling with making inroads on behavior changes. Has reported eliminating heroine but still uses oxy on occasion "to keep sane" Will explore a concrete detox plan. Medically Assisted Treatment referral to acquire prescribed Suboxone. At 9 months client has successfully detoxed from Oxy but still uses alcohol in unsafe amounts socially. If applicable, to link to relevant Progress Notes, check the box at the bottom of the section and list dates of Progress Notes.

Data Field	Identifying Information/Agencies Instructions
Medications as Reported by Person Served on Date of IAP	**NOTE: <u>This section is mandatory for outpatient substance use counseling programs only.</u>** If not applicable, check the box provided. Complete the information in the table as reported by the person served on the date that the IAP was developed. Complete all fields for each medication including name of medication, dose, plans for change (including rate of detoxification), and the person prescribing each medication.

Data Field	Identifying Information/Agencies Instructions
Other Agencies/ Community Supports and Resources Supporting IAP	List the agency name, contact person/title, and services currently being provided by external agencies/community supports and resources that are collaborating on or supporting the person's IAP. Indicate whether or not the appropriate release has been signed to allow for communication with each. Check if "None Reported" or "No Change" **Examples:** • **Other Mental Health agencies** • **State Departments (i.e. DSS, DMR, DMH)** • **Doctor/Nurse** • **Court/Probation Officer**

Data Field	Transition/Level of Care Change/Aftercare/Discharge Plan
Anticipated Date	Record the date of anticipated transition/discharge based on person's belief of when the criteria for such transition would be met and/or provider assessment.
How will the provider/person served/parent/ guardian know that level of care change is warranted?	Transition/aftercare planning should begin as early as possible in the treatment process and documentation of the planning is required. To facilitate the process, check boxes have been provided. If there has been no change since development of the initial or most recently rewritten plan, check "No Change". Otherwise, check all that apply and document evidence, which supports or describes any criteria checked. ***Child Outpatient Example:*** Reduction of symptoms as evidenced by a decrease in anxiety, increase in eye contact, increase in tolerance for frustration most of the time, ability to identify feelings 4 out of 5 times. Attainment of higher level of functioning as evidenced by: ability to engage in reciprocal conversation without cues the majority of the time; ability to be stopped and redirected when going off on a verbal tangent; ability to interact appropriately with peers ***Adult Outpatient Example:*** Treatment is not longer medically necessary as evidenced by: Mary feeling capable to notice and diminish panic attacks to the level that she no longer is worried about them. ***CBFS Example:*** Jean's consistent use of coping skills to reduce daily stress and manage high stress in the moment. In the past, Jean's stress has lead to substance use and suicide attempts so a continued effort to manage her stress will increase her tolerance to upsetting situations. Jean has self-identified that she will feel ready for living independently in the community when she has achieved the ability to administer her own medications accurately and consistently. She has also identified that she will feel more comfortable with the move to independent living if she is able to secure a part time job in order to supplement her income. ***BSAS Example:*** Treatment is no longer necessary as evidenced by :Robert no longer reports drinking to become drunk. He reports he no longer uses alcohol in unsafe amounts socially and has not reported problems resulting from his use of alcohol. Robert reports applying / practicing his newly developed skills for preventing over drinking.

Data Field	Signatures/Confirmation Instructions
Reviewed By (Name, Title, Program)	Record the name of the person completing the review/revision his or her title, and the program(s) for which the plan has been developed.
Was the person served provided with copy of the IAP?	Check appropriate box indicating whether or not the person served received a copy of the IAP. If "No", document reason.
Person's Signature (Optional, if clinically appropriate)	The person served **should** be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a Progress Note and list the date here.
Date	Date of person's signature.
Parent/Guardian Signature	The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives.
Date	Date of Parent/Guardian Signature.

Data Field	Staff Signatures Instructions
Clinician/Provider Print Name/Credentials	**Legible** clinician/provider name and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date:	Date of this signature.
Supervisor Print Name/Credentials (if needed)	**Legible** signature and credentials of supervisor. **Example: Jerry Smith, LMHC**
Date	Date of this signature.
Clinician/Provider Signature	**Legible** signature, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date	Date of this signature.
Supervisor Signature (if needed)	Record the Supervisor's signature if needed.
Date	Date of this signature.
Psychiatrist/MD/DO (if required)	**Legible** physician's signature and credentials if required by agency policy. Please note certain payers do require physician's signature.
Date	Date of this signature.
Next Appointment	Enter the date and time, indicating am or pm for the next scheduled appointment, if known.

Individualized Action Plan: Psychopharmacology

This form is designed to be used for persons who are receiving psychopharmacology services only (i.e. medication management and no therapy). If the person served is receiving other services in addition to medication management, the medication management goals should be included in the IAP. This form is to be completed by the primary provider of psychopharmacology services.

Note: For programs that are accredited by CARF or JCAHO be sure to include legal requirements as they relate to treatment including any restitution, e.g. court ordered treatment. For JCAHO include interaction with the criminal or juvenile justice system if applicable.

Data Field	Identifying Information Instructions (*Fields for Person's Name, Record Number, and D.O.B. must be completed on each page)
*Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
*Record Number	Record your agency's established identification number for the person.
Date of Admission	Record date of admission.
Organization Name	Record the organization for whom you are delivering the service.
*D.O.B	Document date of birth of the person served.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Plan Completed by	Record the name of the person completing the Individualized Action Plan, his or her title, and the program(s) for which the plan is being developed.
Start Date	The date the person served and provider(s) will begin to work on this goal.
Target Completion Date	Record the date by which the person served would like to accomplish the goal or the date by which the person served and provider(s) believe the goal can be completed. This indicates the anticipated duration of treatment.
Adjusted Target Date	If the target date needs to be changed later, the new date is entered here.
Reason for Adjustment	If an adjustment is made to the target date, document the reason for the adjustment here.
Desired Outcomes in Person's Served Words	Document the goal in the words of the person served. This should reflect his or her desired outcome and can be used as a benchmark by the person and provider for determining success in achieving the goal as treatment progresses. ***Adult Outpatient Example:*** "I don't want to experience an episode like those two again… and if I do, I want to know how to respond." ***BSAS Example:*** I need to get off of Oxyies"
State Goal Below in Collaboration with the Person Served as Identified in the	Check off the source(s) (Psychiatric Evaluation and/or Comprehensive Assessment) of the identified need of the person served. Check the appropriate goal(s) in the list provided to indicate the desired outcomes of the person served (family/guardian as appropriate), or check *Other* and specify the goal.
Objectives	Check the appropriate objective(s) which will help person served reach his/her identified goal(s), or check *Other* and specify the objective.
Person's Strengths and Skills and How They Will be Used to Meet Goals	Document the strengths and skills that can be used to work towards accomplishing the person's goals. ***Adult Outpatient Example:*** Mary has skills in caring for others and being compassionate that she can use towards herself. Mary is willing to participate in treatment and wants to "get better." Generally, Mary states she does not like medicine, but she is willing to explore a conversation about her options. ***BSAS Example:*** Client is highly motivated to continue with MAT and has disclosed to his family his past struggle with Oxycodone and use of MAT for support.

Therapeutic Intervention Methods, Provider, Frequency, and Duration	Check the appropriate Therapeutic Intervention Methods and corresponding Provider(s), Frequency, and Duration of services for each intervention. If a therapeutic intervention is not listed, check *Other* and list. If a noted service has a frequency, which may fluctuate check *Other* in the Frequency section and write "See the Follow Up Plan on the Psychiatric Progress Note" or "Refer to _______ (insert name of other documentation source in record, which specifies frequency and rationale).
Referrals/Additional Evaluations	Check box(es) that best identifies additional assessment needs of the person served or check *Other* and list the additional assessment needed. Check none required as applicable.
Explained rationale, benefits, risks and treatment alternatives to/for the person served?	Check *Yes* or *No* if the rationale, benefits, risks and treatment alternatives contained in the Individualized Action Plan: Psychopharmacology were explained to the person served (parent/guardian as appropriate).
Data Field	**Transition/Level of Care Change/Discharge Plan**
Anticipated Date	Record the date of anticipated transition/discharge based on person's belief of when the criteria for such transition would be met and/or the provider's assessment.
How Will the Provider/Person Served/Parent/ Guardian Know That Level of Care Change is Warranted?	If "Other" document evidence, which supports or describes criteria. When discharge is indicated, provider should complete Transition Discharge Summary and Plan.
Data Field	**Referrals, Rationale, and Response Instruction**
Person Served/Guardian Response	Check appropriate response from person served (or parent/guardian as appropriate).
If Person Served refuses plan, describe plan for continuation of services	Document recommendations for follow up services if the person served has not agreed to the IAP: Psychopharmacology.
Person Served received a copy of the IAP?	Check *Yes* or *No* to indicate whether or not the person served received a copy of the IAP: Psychopharmacology. If *No*, provide explanation.

Data Field	Signatures Instruction
Person Signature (Optional if clinically appropriate)	The person served should be given the option to sign the IAP: Psychopharmacology. If the person does not sign, list the reason(s)/explanation, or document the reason(s)/explanation in a progress note (i.e. "See Progress Note dated 01/01/08).
Date	Document the date.
Parent/Guardian Signature (if appropriate)	The parent/guardian signature is necessary if person served is a minor or an adult who has a legal guardian. This space can also be used for any family/significant other as defined by the person served if he/she wishes them involved in process.
Date	Document the date.
Psychiatrist/MD/ DO – Print Name/Credentials	**Legibly** record **Psychiatrist/MD/DO**'s signature and credentials, according to agency policy, and date. Check if *Not applicable*.
Date	Document the date.
Psychiatrist/MD/DO Signature (If needed)	Record signature here.
Date	Document the date.
Next Appointment	Enter the date and time, indicating am or pm for the next scheduled appointment, if known.

Individualized Action Plan: Detoxification

Treatment Planning is a collaborative process and per best practice guidelines, regulatory requirements, and accreditation standards, must demonstrate active participation of the person served and/or his or her parent/guardian. The title, "Individualized Action Plan," has been identified to capture all of the work or "actions", which may be utilized in the course of treatment for persons served by a variety of programs. The Individualized Action Plan (IAP) must be completed for every person served and be linked to the treatment recommendations/assessed needs from the Comprehensive Assessment or other approved document. This form has been designed to facilitate active participation and plan development with the person served and/or his or her parent/guardian and to document the goals and objectives identified collaboratively with the person served, as well as steps that will be taken by the person served, parent/guardian/community, and other providers to achieve the desired goal(s).

The Detox Plan documents the Individualized Action Plan for persons in detoxification programs and should be completed per program protocol by the person or person(s) responsible for planning and delivering care. The form design is based on the **American Society of Addiction Medicine's** (**ASAM**) Patient Placement Criteria and includes six standardized dimensions. The form is designed to incorporate these specific treatment components into the development of individualized action plan.

Note: For programs that are accredited by CARF or JCAHO be sure to include legal requirements as they relate to treatment including any restitution, e.g. court ordered treatment. For JCAHO include interaction with the criminal or juvenile justice system if applicable.

Data Field	Identifying Information Instructions (*Fields for Person's Name, Record Number, and D.O.B. must be completed on each page)
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Date of Admission	Record date of admission.
Organization/Program Name	Record the organization/program for whom you are delivering the service.
D.O.B	Document date of birth of the person served.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Anticipated Discharge Date	Record anticipated discharge date of the person served.
Date Plan Initiated	Record date the IAP was initially developed, including month, date, and year. This is the date the person served signs the plan.
Plan Completed by	Record the name of the person completing the IAP, his or her title, and the program(s) for which the plan is being developed.

Data Field	Linkage and Desired Outcomes Instructions
Linked to Assessed Need(s) # ____ from form dated _____	List the number of the treatment recommendation/assessed needs from the date of an approved form. Check or indicate the *Other* form name that contains the treatment recommendation/assessed need identified. **Example:** **Treatment Recommendations # 1 and 2 from form dated 01/08/07: Assessment**
Desired Outcomes for this Assessed Need in Person's Words	Document in the words of the person served his or her desired outcomes for the assessed need(s). This statement will be utilized in formulating goals and objectives and can be used as a benchmark by the person served and provider for determining success in achieving the goal as treatment progresses. **Examples:** • **I want to stop drinking.** • **I need to find a positive recovery environment.**

Data Field	Treatment Area Goals/Objectives/ Interventions Instructions
Treatment Area	Check if the treatment area for each dimension is considered Active, Referred, Monitoring, or Not Clinically Appropriate. • Active means this area will be addressed during the treatment episode. • Referred is for problems that will not be addressed during the treatment episode, but are issues the clinician will assist the person with as part of the continuing care process. Example: Making an appointment for outpatient mental health treatment for after the person has left the program. • Monitoring means there is a treatment issue that will not be directly addressed during this treatment episode, but will be monitored while in treatment. Example: The nursing staff is monitoring the person's diabetes during treatment. • Not Clinically Appropriate means the treatment area is not applicable or appropriate at this time and no action will be taken.
Goal Target Date	Record the anticipated date the person will attain his or her goals.
Adjusted Target Date	A revised goal target date in the event that changes need to be made with the original anticipated goal target date. The rationale for changes to the goal target date is to be documented in the progress note.
Goal	Check the appropriate box that lists the goal in each treatment area. Each goal section has space that allows the provider to create an individualized goal for the person.
Objectives	Check the appropriate box that lists the objectives in each treatment area. The objectives are designed to assist the person with meeting the goals in each treatment area. Each objective section has space that allows the provider to create an individualized goal for the person.
Therapeutic Intervention(s)/Method(s)	Describe the actual therapeutic interventions/methods the clinician/trained other staff will provide to support/facilitate the person served in achieving the stated objective. *This is not the type or modality of the service (i.e. do not write "CBT" or "individual therapy" alone. The statement should be descriptive of the actual methods).* **Examples:** • **Teach/build relapse prevention skills.** • **Help person identify strengths and interests.** • **Use CBT to assist person served in identifying triggers .** • **Connect person served to available community resources.**
Frequency	Indicate how often this service/activity will occur. For some services, the total number of hours ordered may need to be included. Please refer to agency-specific guidelines.
Responsible: (Type of Provider)	Indicate the credentials and title of the program staff, not the specific individuals responsible for providing the services listed. If the types of providers listed are not eligible to provide the service according to regulation or payer rules, the service may not be billable. If services are provided in a team format, the primary provider type should be listed. **Examples:** • **Internal Medicine** • **Nurse** • **Therapist** • **Case manager**

Data Field	Client Review/Goal Agreement Instructions
Person Understands?	The person served indicates whether or not he/she understands the goal and a mark is placed in the appropriate check box. If the person served does not understand, an explanation should be written in a progress note for the date of the IAP.
Person Agrees?	If the person served agrees with goal check *Yes*. If the person served does not agree with goal, check *No* and document the content of the discussion and outcome in a progress note on the date of the IAP.
Person's Initials	Person served should initial to document active participation in goal development.

Data Field	Person's Strengths/Skills/Supports Instructions
Person's Strengths and Skills and How They Will be Used to Meet Goals	Document the strengths and skills that can be used towards accomplishing the goals. **Examples:** • **Person served can read at the high school level.** • **Person's family is still very involved and will provide support for medication management, transportation, and opportunities for socialization.** • **Person has group of close friends from residence with whom he can socialize.** • **Person served currently works in a fast food restaurant and can follow fairly complex instructions.** • **Person served is healthy and is not on any medications for medical conditions.**
Supports and Resources Needed to Meet Goals	List supports and resources needed to accomplish goals. Include natural and community supports; cultural and linguistic needs of the person; and any reasonable accommodations/modifications to policies or practices that will be made. Be sure to consider supports beyond the behavioral health system to facilitate recovery and resiliency. **Examples:** • **AA meetings, church, community support meetings** • **An interpreter, written materials in another language** • **Meeting space in an area accessible by wheel chair** • **Peer support worker**
Potential Barriers to Meeting Goals	Record any potential barriers to meeting goals, which the person served identifies or were identified in the development of the Individualized Action Plan. **Examples:** • **Person served does not have drivers license.** • **Person served does not have a stable recovery environment.**

Data Field	Transition/Level of Care Change/Discharge Plan
Anticipated Date	Record the anticipated date transition/discharge based on the person's belief of when the criteria for such transition would be met, and/or on the provider assessment.
How will the provider/person served/parent/ guardian know that level of care change is warranted?	Check all that apply and document evidence, which supports or describes any criteria checked.

Data Field	Signatures Instructions
Person's Signature (optional, if clinically appropriate	The person served should be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a progress note and list the date here.
Date	Date of person's signature.
Parent/Guardian Signature (if appropriate)	The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives. Check if *N/A*.
Date	Date of parent/guardian signature.
Clinical/Provider / Print Name/Credentials	**Legibly** record the name and credentials (according to agency policy) of the primary provider of services, coordinator of services, or the author of the plan.
Date	Date of signature.
Supervisor Name/ Credentials (if needed)	**Legibly** record the name and credentials of the supervisor. **Example: Jerry Smith, LMHC**
Date	Record the date of signature.
Clinician/Provider Signature	Record the Clinician's signature.
Date	Record the date of signature.
Supervisor Signature (if needed)	Record the Supervisor's signature if needed.
Date	Record the date of signature.
Psychiatrist/MD/DO (if required)	**Legibly** record the Psychiatrist/MD/DO signature and credentials if required by agency policy. Please note that certain payers do require a physician's signature.
Date	Record the date of signature.
Next Appointment	Enter the date and time, indicating am or pm for the next scheduled appointment, if known.

Multi-Disciplinary Team Review/Response

This form is utilized to document review and response of Individualized Action Plans by a multi-disciplinary team (MDT). The intent is for the team to provide feedback to the treating provider to ensure that Individualized Action Plans are high quality and meet the needs of the person served. This process is designed to ensure there is a completed feedback loop where the MDT reviews plans, provides feedback to the treating provider, and adjust plans based on the team review. The review and response process will be determined by individual agency protocol.

Data Field	Identifying Information Instructions
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record number	Record your agency's established identification number for the person.
Date of Admission	Record date the person served was admitted.
Organization/Program Name	Record the organization/program for whom you are delivering the service.
D.O.B	Document person's date of birth.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
MDT Review Date	Document the date of the review.
Plan Completed by	Identify the treating provider including name, title, and program.
Date(s) of Individualized Action Plan(s) Reviewed	Record the date(s) of the Individualized Action Plan(s) being reviewed.
Reason/Type of Review	Check box indicating the reason for the particular review – *Initial, 90 day, Annual, Major Change, Discharge or Other*.

Data Field	MDT Summary
MDT Summary	***Comprehensive Assessed reviewed and approved:*** For DPH/BSAS Services, MDT is required for the Comprehensive Assessment as well as the IAP. Check this box if the MDT approves the both. ***IAP Reviewed and approved:*** For other levels of care, if MDT approves the IAP, check the second box. ***IAP reviewed and the following corrective actions are necessary:*** Check this box if the MDT deems corrective actions are necessary. Document clear, concise and specific corrective actions the treatment provider must do in order for the plan to be approved. ***Comments/questions:*** Document any specific comments or questions for the treating provider.

Data Field	Signatures Instruction
MDT Signature/ Credentials	All persons completing the MDT review must sign with name and credentials.
Date	All persons completing the MDT review must date next to his/her signature.

Data Field	Treating Provider Response to MDT Review
Treating Provider Response to MDT Review	***Note applicable:*** Check this box to indicate there are no corrective actions indicated. ***Corrective Action in Process***: Check this box if corrective actions are planned or are in process based on the results of the MDT review. Describe the corrective actions in detail and provide estimated time frame for completion. For example, if the MDT determined a medication evaluation was necessary, document the date of the evaluation or plans for ensuring an evaluation is going to occur.

	Corrective Action Completed: Check this box if the corrective action outlined by the MDT has been completed. For example, if the MDT cited the treatment plan as needing an additional objective for one of the goals, checking the box indicates the additional objective was added. ***Comments/questions:*** Document any specific comments or questions for the MDT.
Data Field	**Signatures Instructions**
Treating Provider Signature/Credentials	Record the signature
Date	Record the date of signature.
Supervisor Signature/Credentials (if applicable)	**Legibly** record the Supervisor signature and credentials if required by agency policy. Please note that certain payers do require a physician's signature. Check if *N/A*.
Date	Record the date of signature.
Psychiatrist/MD/DO Signature/Credentials (if applicable)	**Legibly** record the Psychiatrist/MD/DO signature and credentials if required by agency policy. Please note that certain payers do require a physician's signature. Check if *N/A*.
Date	Record the date of signature.

Discharge Summary/Transition Plan

The Discharge Summary/Transition Plan is designed as a two-page form, encapsulating the course of treatment, outcomes, and reasons for transition or discharge. This plan should be initiated as early in the treatment as possible to ensure steps are taken to provide continuity of care.

Data Field	Identifying Information Instructions
Person Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record #	Record your agency's established identification number for the person.
Admission Date	Document the date the person was admitted.
Organization/program Name	Record the organization/program for whom you are delivering the service.
D.O.B	Document person's date of birth.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Transition From/To	Check if person is being transitioned internally. Indicate the unit/program from which person is being transitioned and to which unit/program person will be transitioned.
Discharge	Check if person is being discharged from the agency/program.
Last Contact	Document the last date of contact with the person.
Transition/Discharge Date	Document the date that the person is being transitioned or discharged.
Person's location and contact information post discharge/ transition	Indicate person's physical location and contact information, including the specific address and telephone number if known, immediately after discharge. If unknown, check box. This information may be utilized for post-discharge/transition contacts including the gathering of outcomes information. If the person was discharged to a shelter, document all efforts made to prevent this placement.

Data Field	Summary of Treatment
Status at Last Contact	Document the status of the person at last contact and include legal status and criminal activity, if applicable, at the time of discharge.
Summary of Services/Treatment Provided	Provide a narrative summary of the person's presenting issues, services and treatment that were provided. Consider vocational, educational, financial, legal, medical, behavioral and risk status.
Outcomes	Include qualitative and quantitative information regarding the person's progress/gains achieved, strengths, abilities and preferences. Indicate names of any standardized measures used and a summary of the outcome information including vocational/educational/financial status or achievements.
Health and Safety Concerns	Document health and safety concerns; include behavioral, medical and/or substance use issues. Check if Not Applicable.
Goal Status	Check the numbers of the goals addressed in treatment based on Individualized Action Plan. For each goal, identify with a keyword and indicate the status by checking whether that goal at the time of discharge has been met, partially met, not met, or discontinued. Insert any additional comments in the spaces provided.
Overall Progress in Treatment	Document the person's overall progress in treatment.

Data Field	Diagnosis
Axis I – V	Spaces are provided to capture the information gathered at intake and time of Transition/discharge. Indicate the diagnostic code and conditions for Axes I – III according to the instructions from the diagnostic manual being used. For Axis IV, check the relevant categories of psychosocial or environmental problems/stressors and write the specific factors. For Axis V, log the current GAF score as well as the highest and lowest functioning from the past year.

Data Field	Reason for Transition/Discharge
Reasons	Check to indicate reason(s) for transition/discharge.
If involuntary/ administratively discharged, summary of disciplinary action taken	If not applicable, check box provided. Include reasons, as well as the decision of the grievance hearing, or if the client elected not to be heard, a clear statement of the circumstances of termination, suspension, or any lesser sanction imposed. Check whether or not the person was notified of the appeal process.

Data Field	Person's Response
Person's Response to Treatment and Transition/Discharge	Summarize person's response to this treatment episode and how he/she feels regarding the transition/discharge.

Data Field	Medications
Medications as Reported by Person at time of Transition/Discharge	List medication name, dose, plans for change (including rate of Detox). Record the name of the prescriber as reported by the person at the time of transition/discharge.

Data Field	Continuity of Care/Referral Instructions:
Referred To	List all internal and external services/programs to which the person is being referred at the point of transition/discharge. Specify agency/program name, location, and any other contact information the person or parent/guardian will need to ensure continuity of care
For	Specify the types of services or programs, or reason why person is being referred for each particular listing.
Date(s)/Time(s) of Appointments if known	Indicate any specific dates and/or times of appointments that have been set up for the person.
Aftercare Plan and Options	Document information on symptoms the person should watch for, options available if the symptoms reoccur, additional services that may be needed or preferred by the person and follow-up plans.

Data Field	Staff Signatures Instructions
Person Signature	If appropriate, **legibly** record signature of the person or his/her parent/guardian.
Date	Date of this signature.
Parent/Guardian Signature (if appropriate)	If appropriate, legible record signature of the person's parent/guardian.
Clinician/Provider Print Name/Credentials	**Legibly** record name and credentials, according to agency policy, of the clinician/primary provider of services, coordinator of services, or the author of the plan.
Date	Date of this signature.
Supervisor's Signature (if needed)	**Legible** signature and credentials of supervisor. **Example: Jerry Smith, LMHC**

Date	Date of this signature.
Supervisor – Print Name/Credential (if needed)	**Legible** supervisor name and credentials, according to agency policy.
Date	Date of this signature.
Psychiatrist/MD/DO Signature (If needed)	Record signature here.
Date	Date of this signature.
Data Field	**Client Copy**
Copy of Transition/Discharge Plan	Indicate if a copy of the plan has been *given to the person*, *mailed to the person*, or *did not receive a copy*. If person did not receive a copy, provide explanation.